# Seeking Solutions to the Opioid Crisis

J. Stephen McIver

A *Modern Healthcare* briefing on May 17 at Thomas Jefferson University in Philadelphia focused on population-health approaches to the opioid crisis. The panelists were Susan L. Freeman, MD, FACPE, FACE, President and Chief Executive Officer of the Temple Center for Population Health and Chief Medical Officer of the Temple University Health System in Philadelphia; Karen Murphy, PhD, MBA, RN, Pennsylvania Secretary of Health; and David B. Nash, MD, MBA, FACP, Dean of the Jefferson College of Population Health and Editor-in-Chief of *P&T*.

Ending the opioid crisis will require better coordination of care, community involvement in finding solutions, and more consistent use of improved pain-control options, panelists agreed. Responses must overcome limited resources, societal ills that fuel addiction, and the stigma attached to illicit drug use.

Opioids killed more than 33,000 people in 2015, and nearly half died using a prescription opioid. The crisis stretches from the largest cities to the smallest towns. "I've never seen anything like this," Dr. Murphy said. "It is just absolutely everywhere."

Combating this epidemic requires urgent, evidence-based approaches that address clinical, research, and education issues, Dr. Freeman said. Temple is drawing on the CeaseFire model, which was originally developed to reduce violence with a mix of prevention, intervention, and community-mobilization strategies.[1]

Emergency department (ED) personnel must be educated on what to do *after* treating an addict, Dr. Murphy said. Coordination and follow-up are essential. The hand-off to other services must improve, and primary care doctors need more help getting people into treatment.

Dr. Freeman said providers often don't know about existing community resources. Pooling those resources can be problematic because organizations compete for limited funding. Communication is also an issue: Providers who refer patients to organizations for addiction treatment don't notify those organizations, so they can't follow up. She said hospitals must engage their communities in the search for solutions, too.

"We don't have enough of anything right now," Dr. Freeman added. For instance, she said, there are only about 900 methadone clinics nationwide.

In the community setting, state prescription drug monitoring programs (PDMPs)—electronic databases that track controlled substance prescriptions—are a vital resource. "It is critically important that we use the PDMP to identify people who need help and get them help," Dr. Murphy said.

"Pain management and pain control is the issue we need to get our arms around," Dr. Freeman said, pointing to the gap between making patients comfortable and helping them avoid addiction. Not long ago, Dr. Murphy recalled, experts believed that people in pain could not become addicted to opioids.

When it comes to managing pain, Dr. Nash said, "our armamentarium is very limited" and practitioners' use of it varies widely. He cited a study that found unexplained variation in EDs' pain-medication prescribing habits.[2] Such data need to be shared with doctors to let them know their prescribing habits are at odds with colleagues, said Dr. Nash, who advocated the creation of a specialized "pain service" within hospitals.

Several programs have shown success in fighting addiction and other behavioral problems, Dr. Nash said. By educating primary care providers on chronic pain management and safe opioid prescribing, building community coalitions, preventing overdoses, and reversing overdoses with rescue medication, Project Lazarus helped lower the overdose death rate in Wilkes County, North Carolina, by 38% in one year.[3] And when Intermountain Healthcare in Utah embedded behavioral health professionals in physician practices, patients' hospital use decreased.[4]

Without programs to prevent and treat addition, Dr. Nash said, hospitals instead treat the costly end results. For instance, addiction can lead to the need for surgery to replace a heart valve damaged by drugs. The hospital excels at that surgery even as it fails to address the underlying addiction.

Reimbursement for treatment is an issue, too. Dr. Freeman said pharmaceutical options are generally covered, but holistic nonpharmacological approaches often are not. She advocates "bundling" payment for addiction treatment, even with Medicaid.

Taming the epidemic will require changes beyond health care. "Addiction thrives in populations that don't," Dr. Nash said. "It's all about the social determinants of health." The lack of jobs, housing, and stable environments drives addiction. "It's an incredibly complicated problem."

The panelists worried that proposed Medicaid cuts could undermine recent progress. Without more money, Dr. Murphy said, "We have to shift what we're paying for."

In rural areas, the struggle for resources and the stigma of addiction may be even worse. Dr. Murphy told of a young man whose five-year struggle with addiction led to an overdose and a trip to his small-town hospital, where the reception was cold at best. "It is not a moral failure," she said of addiction: "It's a disease of the brain."

## REFERENCES


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